

## **Board: MEDICAL EXAMINERS**

### **GENERAL INFORMATION FOR SUPERVISION AGREEMENTS**

In order to practice as a Physician Assistant (PA) in Montana the PA must have on file with Board in accordance to MCA: [37-20-301](#), a supervision agreement. The following outlines general information for a supervision agreement for new applicants to the State of Montana, a new supervising physician and PA practice relationship or a change in supervising physician.

- A. **Application Fee:** \$25.00 for new Supervision Agreement with Physician Assistant License application.
- B. **Supervising Physician** is defined as a medical doctor or doctor of osteopathy licensed by the Board who agrees to a supervision agreement and duties and delegation agreement.
- C. **Qualification of Supervising Physician:**
  - a. possess a current, active Montana license
  - b. exercises supervision over the physician assistant in accordance with the rules adopted by the Board
  - c. retains professional and legal responsibility for the care and treatment of patients by the physician assistant
- D. **Qualifications for Physician Assistant** must have a current active Montana PA license.

**MONTANA BOARD OF MEDICAL EXAMINERS**  
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**PLEASE TYPE OR PRINT IN INK.**

(Please allow 10 days for processing from the date that the Board has a completed application)

**Application for Supervision Agreement:**

**PHYSICIAN ASSISTANT INFORMATION:**

1. FULL NAME: \_\_\_\_\_  
Last First Middle

2. BUSINESS NAME \_\_\_\_\_

3. BUSINESS ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

4. HOME ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS \_\_\_\_\_

5. TELEPHONE (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Business Home Fax

6. SOCIAL SECURITY NUMBER : \_\_\_\_\_ LICENSE NUMBER : \_\_\_\_\_

7. DEA REG. # \_\_\_\_\_ START DATE: \_\_\_\_\_

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**SUPERVISING PHYSICIAN INFORMATION:**

1. FULL NAME: \_\_\_\_\_  
Last First Middle

2. BUSINESS NAME \_\_\_\_\_

3. BUSINESS ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

4. HOME ADDRESS \_\_\_\_\_  
Street or PO Box # City and State Zip

PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS \_\_\_\_\_

5. TELEPHONE (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Business Home Fax

6. SOCIAL SECURITY NUMBER: \_\_\_\_\_ LICENSE NUMBER: \_\_\_\_\_

7. DEA REG. # \_\_\_\_\_ START DATE: \_\_\_\_\_

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### Requirements for use of a Physician Assistant:

A physician, office, firm, state institution or professional service corporation may not employ or make use of the services of a physician assistant in the practice of medicine unless the physician assistant is supervised by a physician licensed in the State of Montana, possesses a current active Montana PA license and has completed and submitted this Supervision Agreement application form with fee to the Board.

### Scope of Practice:

A physician assistant may diagnosis, examine and treat human conditions, ailments, diseases, injuries or infirmities either physical or mental by any means, method, device or instrumentalities authorized by the supervising physician. The above named supervising physician and physician assistant shall execute a duties and delegation agreement constituting a contract that defines the physician assistant's professional relationship with the supervising physician and the limitations on the physician assistant's practice under the supervision of the supervising physician. The duties and delegation agreement must be kept current by amendment or substitution to reflect changes in the duties of each party occurring over time. ***(All physician assistant's licensed prior to October 1, 2005, shall execute a duties and delegation agreement with their supervising physician by October 1, 2006. Physician assistants licensed after October 1, 2005 must have a duties and delegation agreement on file prior to commencing practice.)***

### Supervision:

A physician assistant is considered the agent of the supervising physician with regard to all duties delegated to the physician assistant. The supervising physician is professionally and legally responsible for the care and treatment of a patient by a physician assistant. The onsite or direct supervision of a physician assistant by the supervising physician is not required if the supervising physician has provided a means of communication between the supervising physician and the physician assistant or has provided an alternate means of supervision in the event of the supervising physician's absence.

### Alternate means of supervision for periods of absence:

When the supervising physician is unavailable by means of communication the following alternate means will apply:

- ☐ The supervising physician will provide for a back up supervising physician(s) to supervise the above listed PA when the supervising physician is unavailable. A list of the back up supervising physician(s) must be on file with the duties and delegation agreement, kept current and available upon request by the Board. ***(Important Note: Having a back up supervising physician doesn't relieve the supervising physician listed in this agreement of the professional and legal responsibilities for the care and treatment of patients by the PA listed above.)***  
OR
- ☐ The physician assistant will cease to practice when the supervising physician is unavailable.

### Chart Review:

The Board of Medical Examiners has set the following for chart review:

- A. Chart review must be conducted at a minimum on a monthly basis.
- B. Chart review may not be less than 10 % under any circumstance.
- C. For a licensed PA, with less than 1 year of full time practice experience from the date of initial licensure, for each new supervision agreement, chart review must be 100% for the first three (3) months of practice. Following the first (3) months of 100% chart review the supervising physician may reduced the chart to not less than 25% for next (3) months.
- D. The supervising physician shall countersign all written entries chart reviewed and document any corrections, errors or guidance provided.
- E. For PA's issued a probationary license, chart review must be 100% until termination of the probationary period by the Board.

## **AFFIDAVITS AND SIGNATURES**

I hereby declare under penalty of perjury the information included in my supervision agreement application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question or request for information may lead to a denial of my application or grounds for subsequent disciplinary action imposed on my licensure. I further affirm that I have read and accepted the licensing statutes and pursuant to my profession, including supervision agreement and duties and delegation agreement, and hereby certify that I will abide by all statutes and rules of the Board of Medical Examiners that pertain to my licensure. I acknowledge and understand that I may not practice medicine independently pursuant to 37-20-104(2) and 37-20-301, MCA.

Physician Assistant:

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(Print Name)

(Signature)

(Date)

## **PRIMARY SUPERVISING PHYSICIAN AFFIRMATION**

I affirm that I have read and understand the current Board of Medical Examiners statutes and rules, including those pertaining to physician assistant, supervision agreements and duties and delegation and my responsibilities as supervising physician. I acknowledge and agree pursuant to 37-20-101, 37-20-301, 37-20-403, MCA to exercise appropriate supervision over the above named PA in accordance with all statutes and rules of the Board of Medical Examiners. I acknowledge and agree that I will retain professional and legal responsibility for the care and treatment of patients by the above named PA. I understand that duties and responsibilities may be delegated, or restrictions imposed, at my discretion, including additional limitations on prescribing and dispensing of drugs above those granted by the Board, pursuant to 37-20-404, MCA, and will be reflected in the duties and delegation agreement.

Supervising Physician:

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(Printed name)

(Signature)

(Date)